

Medical Facilities Licensing | Licensing Division P.O. Box 30205, Lansing, MI 48909 Telephone: 517- 284-8599 CRA-Applications@Michigan.gov

<u>ATTESTATION C - INDIVIDUAL</u> VERIFICATION & AFFIDAVIT OF FULL DISCLOSURE

(To be completed and submitted by the applicant)

Add additional pages of this form if authorizing more than one contact person.

I,	· ·
	Name of Sole Proprietor
coi	nfirm the following:
1.	I am the individual responsible for submitting this application and have full authority to execute this affidavit of full disclosure.
2.	I authorize
	E-mail Address: Phone Number:
	Accela Citizen Access Login User ID (if applicable):
3.	I authorize the person listed as the Person Completing Application within the demographic section of the application to be a contact person for the Agency. I understand that this person will have access to records and material submitted to the Agency for the purposes of this application. Further, I understand that this person will retain access and receive communication from the Agency regarding the applicant/licensee until the applicant/licensee submits an official request to remove this person's access and cease communication with this person.
4.	I affirm that the information contained in this application is true, complete, and accurate to the best of my knowledge and

- belief.
- 5. Except as reported in this application, I have no agreements or understandings with any person or entity and no present intent to hold as agent, nominee, or otherwise any interest in the application.
- 6. Except as reported in this application, I have no agreements or understanding with any person or entity and no present intent to pay any sums of money or give anything of value as, including but without limitation, a finder's fee or commission to any person or entity related to the interest in this application.
- 7. I understand that the sole proprietor has an ongoing obligation to notify the Agency should the sole proprietor enter into any such agreement contemplated by this attestation.

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